Life and Disability Income Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. All new life or disability income coverage or any increases in life or disability income coverage will require evidence of insurability (proof of good health) if plan participation requirements are not met. Any references to life or disability income coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor **County of San Luis Obispo**			**Group/Plan Number** **316407**	**Account Number/Location** **37**
Class/Occupation	**Date of Hire**	**Annual Salary**	**Employment Status:**	☐ Active Full-Time ☐ Retired ☐ Active Part-Time
This change is due to: (check all that apply) ___ Initial Eligibility Following Hire	___Change in Coverage Amount ___Late Entrant*	___Other: _____		**Effective Date of Coverage or Change:**

**A late entrant is an individual who is enrolling for supplemental or dependent life or disability income coverage 31 days after first becoming eligible.*

Employee Information

Employee Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth / /	Social Security #	Employee I.D. #
Employee Address *(street address, city, state, zip code)*			Telephone Work ( ) Home ( )	

Employee Life Coverage *(Note: Basic Life/Basic AD&D insurance is employer provided.)*

Basic Life/Basic AD&D	☐ Class 1 ($50,000): Elected Officials, Department Heads and General Management Employees ☐ Class 2 ($30,000): Operations and Staff Management Employees, Confidential Employees, Attorneys, and District Attorney Investigators

Employee Supplemental Life Coverage (Subject to a supplemental life plan maximum of $300,000.) *(Note: Supplemental Life is 100% employee paid)*

Supplemental Life/AD&D **Employee Date of Birth:** _____/_____/_____	Guaranteed Issue (GI) Limit = 2 x times annual salary (rounded to next higher $1,000) or $250,000, whichever is less. When you are first eligible for supplemental life coverage (within 31 days of first becoming eligible), you can elect up to the GI Limit without evidence of insurability. Total supplemental life coverage up to $300,000 is available if you complete an Evidence of Insurability form and ReliaStar Life approves it.

Supplemental Life/AD&D		
Class 1: Elected Officials, Department Heads and General Management Employees **Class 2: Operations and Staff Management Employees, Confidential Employees, Attorneys, and District Attorney Investigators**	I currently have supplemental life/AD&D coverage of: $_____. I am applying for additional supplemental life coverage of: ☐ 1 Times Basic Annual Earnings to a max of $300,000 ☐ 2 Times Basic Annual Earnings to a max of $300,000 ☐ 3 Times Basic Annual Earnings to a max of $300,000 Total supplemental life/AD&D coverage (current plus additional): $_____.	Waive: ☐
Class 3: Trades and Crafts Employees	I am applying for supplemental life (no AD&D) coverage of: ☐ $15,000 or ☐ $50,000	Waive: ☐

Dependent Spouse Supplemental Life Coverage (Subject to a supplemental life plan maximum of 50% of employee's Supplemental Life Amount)

Spouse Life **Name** _____	When you are initially eligible for dependent spouse coverage (within 31 days of first becoming eligible), you can elect up to $20,000 in coverage without evidence of insurability. Total spouse coverage up to $150,000 is available if your spouse completes an Evidence of Insurability form and ReliaStar Life approves it. **Spouse coverage is limited to 50% of the employee's coverage amount.**	
Supplemental Life Election **CLASS 1 and CLASS 2**	I currently have Spouse supplemental life coverage of: $_____. I am applying for 50% of Employee Supplemental Life Amount coverage of: $_____. Total Spouse supplemental life coverage (current plus additional): $_____.	Waive: ☐

Note: The employee is the beneficiary for any dependent spouse insurance coverage.

Dependent Child(ren) Life Coverage (Subject to a supplemental life plan maximum of $10,000.)

Child(ren) Life Insurance CLASS 1 and CLASS 2	When you are initially eligible for dependent child(ren) coverage (within 31 days of first becoming eligible), you can elect it without evidence of insurability. At all other times, you must complete an Evidence of Insurability form for your child(ren) and ReliaStar Life must approve it. **Dependent coverage is limited to 50% of the employee's coverage amount.** Children age birth days to 6 months of age are covered for $500 of the elected amount.	
Child(ren) Life Insurance Election	For Dependent UNIT Age 6 months to age 23, to age 25 if full time dependent student ☐ $ 10,000	Waive: ☐

Note: The employee is the beneficiary for any dependent child(ren) insurance coverage.

Disability Income Coverage

When you are first eligible for disability income coverage (within 31 days of first becoming eligible), you can elect it without evidence of insurability. If you are a late entrant, you must complete an Evidence of Insurability form and ReliaStar Life must approve it.	
Monthly Income Benefits (LTD)	☒ Elected Officials, Department Heads, General Management Employees, Operations and Staff Management Employees, Confidential Employees, Attorneys, and District Attorney Investigators. *(Note: LTD coverage is employer provided.)*

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary *(last name, first, middle initial)*	Relationship to Employee	Benefit % *(MUST total 100%)*

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW ▼

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.**
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature	Date Signed / /

FOR EMPLOYER/PLAN SPONSOR USE ONLY

COVERAGE	LTD
ACCOUNT	
CLASS	
AMOUNT	
EFF. DATE	

COVERAGE	BASIC LIFE	BASIC AD&D	SUPPL LIFE	SUPP AD&D	SPOUSE LIFE	CHILD LIFE
ACCOUNT						
CLASS						
AMOUNT						
EFF. DATE						